Department of Managed Health Care

State of California

Award # 1177113196953 Details

Submit Objection

Proceeding: 2004-0115 Access to Language Assistance (SB853)

Date Requested: 4/20/2007 4:53:17 PM

Amount Requested: $25365

Contribution to the Proceeding: Health Access provided detailed written testimony on the regulations. Some but not all of the comments made resulted in changes made to the regulation.

Task Performed

Activity Hearing

Activity Date 12/1/2006

Amount Billed: $25365

Other Parties Involved: Health Access acted independently of other parties involved in the proceeding.

Subject Matter and Work Description: Health Access provided recommendations concerning the following sections of the proposed regulations: S1367.04 b lacks clarity or statutory authority in the requirement for plans to survey the language needs of the plan's enrollees by using state demographic data rather the population data specific to the plan's own enrollees. S1367.04 a and f does not contain enough specificity to demonstrate how plans will gauge compliance at the provider level. We included a synopsis of the Video Medical Interpretation Project that demonstrates reduced costs and greater availability of interpretation services using information gained through a internet video teleconferencing capability. We supported the provision of interpretation services at no cost to the enrollee. We also strongly opposed the elimination of S1300.67.8 f regarding notices, appeals, and other communication provisions. We strongly opposed the language in S1300.67.04 a 1 that these provisions should not apply to Medicare enrollees. We also opposed the "deemed compliance" provision for Medi-Cal patients because no agency will be monitoring the language assistance programs for the non-Medi-Cal population. While Health Access generally supported the second revision of the regulation, we opposed the third revision. This was because it appeared to represent a significant retrenchment from requirements imposed on plans. These included: translation of vital documents in S1300.67.04 c F 11, giving the plans more permissive language in developing a demographic profile of its enrollees, objecting to the special provisions for specialized plans for which no statutory authority exists, and urging strong agency compliance monitoring and stronger language on provider cooperation. Written testimony will be sent as an attachment to this application.

Time Spent: 88.5 hours

Witnesses: Anthony Wright, Executive Director, Health Access.

Pleading Number: 2004-0115

Contact Information

Organization Health Access California

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	Governing Body
Title	Executive Director
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HEALTH ACCESS
INTERVENER FEES : DEPARTMENT OF MANAGED HEALTH CARE
Regulation Number: 2004-0115
Access to Language Assistance (SB853)

2004-0115	Time recorded for:	Beth Capell, Health Care Policy Expert			
Date	Time	Activity	Time Elapsed Number of Hours	Hourly Rate	Billed Amount
1/13/2006	10:30am-11:30am	Analysis of proposed text	1	$ 370.00	$ 370.00
2/13/2006	11:30-12pm 1pm-2pm	Analysis of proposed text	1.5	$ 370.00	$ 555.00
3/3/2006	12pm-1pm	Review of comments due March 3, 2006	1	$ 370.00	$ 370.00
9/22/2006	11am-11:30am	Discussion and analysis of proposed text	0.5	$ 370.00	$ 185.00
9/23/2006	6:30am-7am	Review of CPEHN's comments	0.5	$ 370.00	$ 185.00
		Total; Beth Capell	*4.5*		*$ 1,665.00*
2004-0115	**Time recorded for:**	**Elizabeth Abbott, Health Care Policy Expert**			
2/14/2006	8am-6pm	Attended DMHC hearing in Los Angeles (including travel time)	10	$ 370.00	$ 3,7000.00
3/14/2006	12:30pm-6:30pm	DMHC sponsored tour of the VMI system at San Joaquin Hospital in Stockton (including transportation time)[1]	6	$ 370.00	$ 2,220.00
11/30/2006	9am-5:00pm	Researched and prepared written comments due December 3, 2006	8	$ 370.00	$ 2,960.00
12/1/2006	8am-5pm	Researched and prepared written comments due December 3, 2006	9	$ 370.00	$ 3,330.00
12/21/2006	2pm-5pm	Review of third revision of the proposed regulation to prepare for a DMHC telephone meeting and conference call	3	$ 370.00	$ 1,110.00
3/1/2007	10am-11am	Spoke at a DMHC press briefing at the UC Davis Medical Center in Sacramento	1	$ 370.00	$ 370.00
		Total; Elizabeth Abbott	*37*		$ 13,690.00
2004-0115	**Time recorded for:**	**Anthony Wright, Health Care Consumer Advocate; Executive Director, Health Access**			

[1] The Video Medical Interpretation Project implemented by Health Access provide a working model of real-time, facility-wide interpretive services that are effective, practical, and fiscally responsible. Its demonstration directly refutes provider claims to the contrary.

2/16/2006	9:30am- 11:30am	Organization/coordination of individuals for hearing in Oakland on February 16, 2007	2	$ 250.00	$ 500.00
3/1/2006	2pm-7pm	Compilation and editing of comments due March 3, 2006	5	$ 250.00	$ 1,2500.00
3/3/2006	1pm-3pm	Review and approval of comments due March 3, 2006	2	$ 250.00	$ 500.00
3/14/2006	12:30pm-6:30pm	DMHC sponsored tour of the VMI system at San Joaquin Hospital in Stockton (including transportation time)[1]	6	$ 250.00	$ 1,500.00
9/22/2006	2pm-6pm	Reviewed, edited and approved comments due September 25, 2006	4	$ 250.00	$ 1000.00
12/1/2006	10am-12pm	Reviewed, edited and approved comments due December 3, 2006	2	$ 250.00	$ 500.00
		Total; Anthony Wright	*21*		*$ 5,250.00*
2004-0115	**Time recorded for:**	**Bruce Occena, Project Director, Video Medical Interpretation Pilot Project with San Francisco General Hospital and Alameda County Medical Center**			
2/10/2006	10am-11am	Preparation of written testimony for hearing in Oakland on February 16, 2006	1	$ 370.00	$ 370.00
2/15/2006	9am-1pm	Orientations to SFGH and ACMC regarding the February 16, 2006 hearing in Oakland	4	$ 370.00	$ 1,480.00
2/16/2006	11:30am-2:30pm	Attended and testified at DMHC hearing in Oakland	3	$ 370.00	$ 1,110.00
		Total; Bruce Occena	*8*		*$ 2,960.00*
2004-0115	**Time recorded for:**	**Hanh Kim Quach, Health Care Policy Coordinator**			
2/16/2006	10:15am-3:45pm	Attended and took notes at the DMHC hearing in Oakland on February 16, 2006 (including travel time). Fact-finding to inform response.	5	$ 100.00	$ 500.00
3/14/2006	12:30pm-6:30pm	DMHC sponsored tour of the VMI system at San Joaquin Hospital in Stockton (including transportation time)[1]	6	$ 100.00	$ 600.00

[1] The Video Medical Interpretation Project implemented by Health Access provide a working model of real-time, facility-wide interpretive services that are effective, practical, and fiscally responsible. Its demonstration directly refutes provider claims to the contrary.

		Total; Hanh Kim Quach	*11*		*$ 1,100.00*
2004-0115	**Time recorded for:**	**Norma Martinez-HoSang, Community Organizer**			
2/16/2006	10am-4pm	Attended DMHC hearing in Los Angeles on February 14, 2006. Fact-finding to inform response.	6	$ 100.00	$ 600.00
		Total; Norma Martinez-HoSang	*6*		*$ 600.00*
2004-0115	**Time recorded for:**	**Jessica Rothhaar, Community Organizer**			
2/16/2006	11:30am-12:30pm	Attended the DMHC hearing in Oakland. Fact-finding to inform response.	1	$ 100.00	$ 100.00
		Total; Jessica Rothhaar	*1*		*$ 100.00*
		Total Time & Amount Billed	**88.5**		**$ 25,365.00**

[1] The Video Medical Interpretation Project implemented by Health Access provide a working model of real-time, facility-wide interpretive services that are effective, practical, and fiscally responsible. Its demonstration directly refutes provider claims to the contrary.

HEALTH ACCESS

ELIZABETH ABBOTT joined Health Access in January 2006 as their Project Director where she focuses on federal health programs and the impact they have on beneficiaries and public policy in California. She previously served as the Regional Administrator of the Centers for Medicare and Medicaid Services (CMS) in Region IX which serves the states of California, Arizona, Nevada, Hawaii, and the Far Pacific (including the Pacific Trust Territories of Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.)

She was responsible for the oversight of State Medicaid agencies, State survey and provider certification operations, State Children's' Health Insurance Programs, and managed care organizations. The San Francisco Region spans a vast geographic area, has one of the most culturally diverse populations in the nation, serves over 10 million beneficiaries, and has a programmatic budget exceeding $30 billion per year.

Ms. Abbott joined CMS as the Associate Regional Administrator for Medicare in 1993 where she managed technical, clinical, and financial staff and oversaw Medicare contractors that serve providers and beneficiaries in the West. Prior to joining CMS, she worked in progressively more responsible positions with the Social Security Administration (SSA) in 17 field and regional offices in Massachusetts, Connecticut, Illinois, Indiana, and throughout California.

Ms. Abbott has a B.A. in psychology from the University of Redlands in Redlands, California and has done graduate work in public administration at the University of Southern California.

BETH CAPELL, PH.D., *Capell & Assoc.* has been the principal and owner of Capell & Assoc. since its founding in 1995. She has thirty years of experience in Sacramento, working in the Legislature, various Administrations, and with various interest groups.

She represents Health Access California; Health Access Foundation; the California Physicians Alliance; State Council of Service Employees International Union, AFL-CIO; and other consumer and labor organizations in both legislative activity and regulatory action.

Health Access California sponsored the package of legislation known as the HMO Patient Bill of Rights from 1995 to its enactment in 1999. Health Access Foundation led a collaborative of consumer groups that monitored initial implementation of the more than 20 pieces of legislation enacted between 1995 and 2000 intended to protect consumers from HMOs. Health Access Foundation has continued to work on implementation and ongoing monitoring of the law with respect to consumer protections against HMOs. Beth Capell has been an architect and active advocate throughout this decade of efforts.

Beth Capell has worked on issues including prescription drugs, universal access, hospital overcharging, balance billing by physicians, nursing home regulations, hospital standards, health insurance regulation, and other health care issues.

Prior to establishing Capell & Assoc. Beth Capell represented the California Nurses Association from 1986 to 1995, first as the legislative advocate and later as the Director of Government Relations for the association. From 1983 to 1986, Ms. Capell worked at the California Manufacturers Association, working on job training and human resource issues, including health insurance. From 1977 to 1983, Ms. Capell worked in various positions in the Legislature, the Administration, and other efforts.

Ms. Capell has Ph.D. in political science from the University of California, Berkeley, and continues to publish articles and present papers on political science, specifically interest groups, legislatures, and the impact of legislative term limits.

ANTHONY WRIGHT serves as Executive Director for Health Access California, the statewide health care consumer advocacy coalition, working on behalf of the insured and uninsured, made up of over 200

organizations representing seniors, children, working families, people with disabilities, immigrants, people of faith, labor, and communities of color.

Under Wright's leadership since 2002, Health Access has been a leader in efforts to fight health care budget cuts, to expand both employer-based coverage and public insurance programs, to advance consumer protections, and to address the causes of medical debt. For example, his work on hospital overcharging and abusive billing and collections practices led to both to legislative action and hospital guidelines on the issue. Recently, he served as co-chair and campaign manager for the No on 78/Yes on 79 initiative effort, facing the prescription drug industry and the most expensive ballot campaign in the nation's history.

Wright's background is as a consumer advocate and community organizer, and he has been widely quoted in local and national media on a range of issues. He served as Program Director for New Jersey Citizen Action. As coordinator of New Jersey's health care consumer coalition, he ran successful campaigns to win HMO patient protections, defeat for-profit takeovers of nonprofit hospitals and Blue Cross Blue Shield, pass a law to govern hospital conversions and acquisitions, and expand coverage for low- and moderate-income children and parents.

Wright also worked at the Center for Media Education in Washington, DC, *The Nation* magazine in New York, and in Vice President Gore's office in the White House. Born and raised in the Bronx, Wright graduated from Amherst College magna cum laude in both English and Sociology.

BRUCE OCEAN is the director of the Heath Access Video Medical Interpretation Project to implement this new technology to assist patients in getting linguistically appropriate care. . For the past two years he has provided direct oversight of a pilot project to install this technology system--wide at Alameda County Medical Center and San Francisco General Hospital creating a partnership for shared interpretive services between Northern California's two largest public hospitals.

Working out of our Oakland office, he comes to Health Access us from running the Substance Abuse Program at the San Francisco Department of Public Health, and decades of political and programmatic work.

NORMA MARTINEZ-HOSANG, our Southern California Regional Organizer, has been a community and labor organizer and trainer in the Los Angeles region for the last ten years. She served as a field organizer and lead organizer with Californians for Justice, overseeing several large-scale precinct and voter education efforts across Southern California. Most recently, she served as lead organizer for the California Nurses Association, leading several successful union election campaigns. She is a former board member of the National Organizer's Alliance.

HANH KIM QUACH is a Health Care Policy Coordinator for Health Access. Before joining the organization, she worked as a journalist for nearly 9 years. She started her career covering rodeos, Easter egg hunts, and homicides in Tucson, Arizona, while finishing college at the University of Arizona. After graduation, she joined The Fresno Bee, where she wrote about public schools in the southern San Joaquin Valley. Her final six years in journalism were spent in Sacramento as a Capitol reporter for the Orange County Register, where she covered a variety of issues which included workers' compensation insurance, the state budget, collective bargaining among physicians and other state issues.

JESSICA ROTHHAAR, our Northern California Regional Organizer, has been a lobbyist, policy advocate and community organizer for 20 years. She has worked on a broad variety of issues affecting public health, child and family well-being and community development, and has lobbied on federal, state, and local budget issues in California, Washington, D.C., and London, England. Prior to joining Health Access, she ran her own consulting firm specializing in policy advocacy for nonprofits and foundations in California.

FOUNDATION

December 1, 2006

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Suzanne Chammout, RN, JD, Regulation Coordinator

Re: Language Assistance Programs, Control # 2004-0115

Dear Ms. Ehnes,

Health Access, a coalition of more than 200 consumer, community and other organizations, offers comments on the proposed regulations on language assistance programs as revised on November 17, 2006. These regulations result from SB 853 by Senator Martha Escutia (D-Whittier).

We begin our comments by expressing concern at what appears to be some retrenchment by the Department of Managed Health Care in the promulgation of the Language Assistance Programs Regulation. While we have been largely supportive of this important regulation development in our past comments, we find this version considerably less protective of consumers' rights to language assistance. We also believe that the softening of the language has resulted in lack of clarity in certain sections. We are also disappointed to note that language that was specifically added in previous revisions to strengthen definitions, requirements, and enforcement has been deleted as part of this revised version.

In the past, we have urged The Department to conclude the regulatory process and we encouraged expedited implementation; we now believe this regulation as written requires revision. We note that some of the changes seem to be designed to reduce requirements for health plans at the expense of establishing the statutorily-mandated assistance and specific protections for low English-proficient populations. In addition to the requirements mandated by SB 853, the fundamental rights are provided for in the original Knox-Keene Act. The lessening of these important consumer protections would contribute to worse health outcomes in California.

Our specific comments are as follows:

414-13th Street, Suite 450 ▪ Oakland, CA 94612-2608
PH 510.873.8787 ▪ FAX 510.873.8789 ▪ www.healthi-access.org

1. **<u>This version includes a more limited definition of 'vital documents' in Section 1300.67.04 (b) (7) (G) which must be translated.</u>** This section has been deleted, and has been moved to 1300.67.04 (c) (F) (ii). However, the revised section does not include all of the vital documents listed in previous versions, specifically what was shown in the deleted section (G) (vi). The new section omits "grievance and independent medical review processes".

   We believe it is critical to include documents intended for enrollees to question and appeal decisions. SB 853 requires that "notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal" be included as a vital document for translation. It is therefore incumbent upon the plans to translate the actual form for filing grievances and requests for independent medical review as well. It would be of little value to advise consumers that they have the right to file a grievance in multiple languages, but then provide the form to exercise that right only in a language they do not understand. In essence, the failure to translate these grievance and related forms into appropriate languages does not afford equal protection and due process rights to low English-proficient enrollees.

2. **<u>The revision to Section (c)(1)(A) through (G) contains more permissive language which allows health service plans to develop a demographic profile of its enrollees rather than the previous requirement for a plan-specific linguistic needs assessment of enrollees.</u>** This section permits the plan to assess the their enrollee population using a "variety of methods. . . including census data, client utilization data from third parties, data from community agencies, and third party enrollment processes." It no longer requires the plan to "assess the linguistic needs and demographic profile of its enrollee population" as required in 1367.04 (b). It removed the requirement for the plan to "identify the non-English languages that are likely to be encountered among the plan's enrollees." Nor does it require the plans, as it did previously, to "estimate the number of enrollees likely to need language assistance." The lack of specificity of the requirements laid out by The Department allows the plans to perform only a very generalized assessment that might not reflect their actual membership.

   Plans that derive their demographic profile from census data and general third party information will likely have a very imprecise picture of their enrollee population. Their enrollees may vary from generalized

demographic information based on the geographic location where they do business in the state, the language diversity of their contracted providers, their targeted marketing strategies aimed at consumers, and other variables. From a practical standpoint, without a specific survey of their enrollees, plans and providers will be ill-equipped to anticipate and later actually provide language-appropriate care in timely fashion.

The language requiring an individual plan-specific enrollee assessment previously included in the regulation should be restored. Without this language, plans will not be able to comply with their obligation to provide access to appropriate care.

3. **The Department established special provisions for specialized plans (dental, vision, chiropractic, acupuncture, and employee assistance program plans) in (4)(d)(9) for which no statutory authority exists.** SB 853 does not recognize, establish, or otherwise contemplate any different standards for specialized plans. The only differentiation among plans in the statute is based on enrollment size. This provision sets a different, substantially more lenient standard for specialized plans which has no basis in the law. This and related sections should be deleted.

4. **The section (d) on compliance monitoring is key to successful implementation of this statute and should be strengthened.** The compliance monitoring section should reflect the stated goal of "evaluating the totality of the plans' language assistance program to determine whether the program as a whole provides meaningful access for LEP enrollees." While the regulation outlines several operational and demographic factors to gauge effectiveness in items (1) through (8), we believe a specific consumer measurement should be added. We urge the addition of "evaluation of the health insurer's programs and services with respect to the insurer's enrollee populations, using processes such as an analysis of complaints and satisfaction survey results." This addition has a strong statutory basis, coming directly from the bill's language. The addition of this assessment tool would round out the previously-enumerated measurements such as a review of the frequency with which particular languages are encountered and the availability of translation and interpretation services and professionals.

5. **The section (e) on implementation should be strengthened by including stronger language on provider cooperation.** The deleted section should be retained. It states: "The contract shall require the

provider to cooperate with the plan by providing any information necessary to the plan's assessment of compliance." This clarifying explanation of the providers' responsibility strengthens this requirement. From a practical audit standpoint, any language that makes it clear that providers must fully cooperate, readily furnish information, and be forthcoming in ensuring compliance would contribute to ensuring smooth implementation and is essential to the plans in ensuring genuine linguistic access to care. In addition, this statement has a strong statutory basis because the language was extracted directly out of the wording of SB 853 and, therefore, should be included in the regulatory language. Failure to include this language in the regulation may contribute to a lack of clarity, leading to confusion by providers about the need to comply.

As supporters of the original legislation, Health Access offers these comments. If you have questions or need more information, please contact Elizabeth Abbott, Health Access at (916) 497-0923 or Beth Capell, Capell & Assoc., at (916) 497-0760.

Sincerely,

/s/
Anthony Wright
Executive Director

CC: Assemblymember Mervyn Dymally, Chair, Assembly Health Committee
Cindy Ehnes, Director, Department of Managed Health Care

FOUNDATION

September 25, 2006

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Suzanne Chammout, RN, JD, Regulation Coordinator

Re: Language Assistance Programs, Control # 2004-0115

Dear Ms. Ehnes,

Health Access, a coalition of more than 200 consumer, community and other organizations, offers comments on the proposed regulations on language assistance programs as revised on July 26, 2006. These regulations result from SB 853 by Senator Martha Escutia (D-Whittier).

We begin by noting that we are supportive of the proposed regulations as amended. The statute established standards and requirements for plans' provision of translation and interpretation services. These include assessing linguistic needs of the enrollees, arranging for and providing translation and interpretation services, training plan for staff, and monitoring compliance with the regulation. We believe that the revisions are consistent with the law and are clear as written. Since the proposed regulation does meet the consistency and clarity standard, we urge The Department to conclude the regulatory process and urge prompt implementation of this regulation. We believe the additional translation and interpretation services afforded in this regulation will provide substantial assistance to low English-proficiency patients and should result in improved health outcomes for all Californians.

We urge energetic and consistent enforcement of this regulation upon enactment. In addition, we look forward to meeting with The Department on the implementation of this important regulation.

As supporters of the original legislation, Health Access offers these comments. If you have questions or need more information, please contact Elizabeth Abbott, Health Access at (916) 497-0923 or Beth Capell, Capell & Assoc., at (916) 497-0760.

414-13th Street, Suite 450 ■ Oakland, CA 94612-2608
PH 510.873.8787 ■ FAX 510.873.8789 ■ www.health-access.org

Sincerely,

Anthony Wright
Executive Director

CC: Senator Martha Escutia
Senator Jackie Speier, Chair, Senate Banking, Finance and Insurance Committee
Assemblymember Mervyn Dymally, Chair, Assembly Health Committee
Cindy Ehnes, Director, Department of Managed Health Care

March 3, 2006

Lucinda Ehnes, Director
Department of Managed Health Care
980 Ninth St., Ste.
Sacramento, CA. 95814
Attn.: Suzanne Chammout, RN, JD
Mark Summner, Staff Counsel
Office of Legal Services

Re: Language Assistance Programs: File No. 2004-0115

Dear Ms. Ehnes,

Health Access California, the statewide health care consumer advocacy coalition of more than 200 community, consumer and other organizations, offers comments on the regulation package, file no. 2004-0115, on language assistance programs.

These regulations arise from specific legislation, SB853 (Escutia), C.713 of 2003. Consistency with that statute as well as with the Knox-Keene Act are important considerations in reviewing the proposed regulation.

1. Needs Assessment:

S.1367.04 (b) states:

> In developing the regulations, the department shall require every health care service plan and specialized plan to assess the need of the enrollee population, excluding the Medi-Cal population, and to provide for translation and interpretation of medical services, as indicated.

The proposed regulations lack either clarity or statutory authority. The intent of the statute is to assure that each plan has an accurate understanding of the language access needs of its own enrollees. The proposed regulation in (c) (1) (A)(i) refers to "collecting LEP enrollee data through a variety of methods, which be designed to identify accurately the language needs of the plan's enrollees, including statistically valid methods for population analysis".

This may be construed to allow use of broad population data (all Californians or all Californians enrolled in health plans) rather than population data specific to a plan's own enrollees. Given that language access needs vary by region, a statewide survey is not likely to be particularly helpful in determining language access needs in a manner that will assure that those needs are met. For example, Sacramento has a substantial concentration of Russian language speakers, Santa Clara does not.

The intent of the needs assessment is not simply to collect data: it is to create the information each plan needs to meet the language access demands of each of its own enrollees.

2. Contracting Providers: Timely Access to Linguistically Appropriate Services

The statute, S.1367.04 (a) and (f) plainly require that the requirements for timely access to linguistically appropriate services apply to contracting providers, including doctors, hospitals, risk-bearing organizations and the providers that contract with risk-bearing organizations.

The regulation in essence requires a plan to have a policy or procedure for assuring language access at the point of contact for clinical services. Plans must be able to demonstrate that enrollees can actually obtain these services from providers. Allowing each plan to determine its own plan or procedure for assuring compliance imposes on the department the burden of determining whether compliance reaches the provider level or not. We fail to see in the proposed regulations any method or means for demonstrating compliance at the provider level. We are troubled by this because of our familiarity with other regulations that appear adequate on the surface but that lack compliance at the provider level: for example, plans have for thirty years filed policies regarding timely access to care yet are unable to demonstrate routine compliance with their own self-defined policies.

Amending provider contracts is a necessary step toward assuring compliance but it is not sufficient. We ask: how will compliance at the provider level be demonstrated?

Given recent studies on the language access at hospitals in Alameda County, all of which should have been complying with Sec. 1259 of the Health and Safety Code, we question whether that is sufficient to meet the standards of SB853, a later-enacted statute. At a minimum, contracting hospitals should be required to demonstrate compliance with Sec. 1259, something they are plainly not doing now.

3. Cost and Availability of Interpretation Services

Health Access California has conducted pilot projects with Bay Area public hospitals that were designed to test whether it was possible to use technology, specifically the Internet videoconferencing, to provide access to interpretation services that included not only voice (as is done over the telephone) but also television-quality video. This allows a clinic in Hayward that has a Cantonese speaking patient to access an interpreter at Highland Hospital in Oakland: literally the physician and the patient can be in an exam room in Hayward with a computer screen that allows them to see and hear a trained medical interpreter in Oakland.

One important note: Having served as an incubator for this effort, testing the idea through the Health Access Foundation, we are in the process of spinning it off, as VMI

gets integrated in the hospitals operations. It is our role to test ideas, not to benefit from their commercial development.

Video transmission provides the efficiencies and cost savings associated with remote transmission, while maintaining visual "body language" cues in the interpretive interaction.

When we embarked on this project in 1999-2000, the technical capacity to provide real-time video capacity in a clinical setting was just barely available and affordable. Since 2000, the cost of computers has continued to decline while the technical capacity for real-time video conferencing has improved dramatically.

At the same time, the push for electronic medical or health records has meant that many providers serving commercial plan enrollees and other Californians are moving toward adopting technology that could be compatible with video medical interpretation, if they incorporated that need into their planning.

Indeed these language access regulations come at a critical moment: just as various risk bearing organizations, physician groups and other providers are creating the technical capacity for electronic health records. Setting a standard for language access that permits use of video medical interpretation as one means of meeting that requirement can be compatible with the adoption of electronic health records if efforts are made now.

In 1999-2000, Health Access set out to test the idea of substituting video medical interpretation for live interpreters in several of the most challenging clinical settings in California, the Alameda County Medical Center and San Francisco General Hospital and their related clinics; the hospitals receive approximately 200,000 requests for interpretation annually. Both facilities had a tradition of providing a range of interpretation services with about 50 full-time interpreters between them. Both facilities were county hospitals, challenged by short-funding and other management difficulties that made innovation more difficult.

The shared goal of these health systems and Health Access Foundation was to find a cost-effective way to provide interpreter services to the multi-ethnic, multilingual population that seek help at the 236-bed Alameda County Medical Center and 550-bed San Francisco General Hospital, both major urban hospitals.

Beginning September 2005, Health Access' Videoconferencing Medical Interpretation (VMI) project conducted weekly clinical trials to test the exchange of interpreter services between the two hospitals.

As of January 2006, the hospitals have conducted 7,000 successful transmissions. Wait times for interpreter services have been slashed from 45 minutes previously to less than 10 minutes now. The electronic connection to a VMI interpreter takes less than one minute.

More than 30 VMI units are being used daily at ACMC and SFGH – a number that is expected to double this year.

VMI is now in used 100% of ACMC's ambulatory care clinics, including links to three community clinics. This year, ACMC plans to extend VMI to inpatient units, emergency department and pharmacy.

At SFGH, VMI is provided in all primary care clinics. This year, the hospital plans to expand the technology to all ambulatory care clinics, as well as linking three or four SF-DPH community clinics.

The project has provided services in twenty-one languages: Amharic, Arabic, Bosnian, Cambodian, Cantonese, Dari, Farsi, Hindi, Korean, Lao, Mandarin, Mien, Pashtu, Punjabi, Russian, Spanish, Tagalog, Thai, Tigrigna, Urdu and Vietnamese.

The equipment needs for this project were:

- Video-conferencing units.
    - Our project is using the Tandberg 1000 with wireless support.
        - The standalone unit is used independent of a computer or laptop.
        - The unit has a wide-angle lens, allowing both the physician and patient to be in the frame at a comfortable distance.
        - Video quality was similar to television.
        - Audio quality was better than speaker phone quality.
        - Units were mounted on mobile carts, making them easily maneuverable and stable.
    - PolyCom is another company that manufacturers this technology.

- Quantity
    - We used one to three mobile video units per clinic
    - Actual number depends on two variables:
        - Size of clinic (number of exam rooms, layout, number of clinics sharing the venue, etc.)
        - Demand for interpretation (percent of limited-English proficient patients.)

      Example: One general medicine clinic, open mornings and afternoons, with 40% LEPs and 12 exam rooms required three video-conferencing units.

- Information Technology Foundation
    - At both medical centers, VMI rests upon existing internet networks.

  Note: Because interpretation demands were so high, video interpretations were segregated to its own VLAN. That means facilities would need to have enough bandwidth capacity to accommodate the video traffic. Health Access is able to provide more technical advice upon request.

The list price for the technology is about $5,000, although for our project, the per-unit cost tends to be lower than that. This is in addition to the computer capacity. Given the rapid adoption of electronic medical records and the declining cost of computer capacity, the incremental cost is the cost of the video-conferencing unit plus the cost of interpretation services.

In addition to our partnership with Alameda County Medical Center and San Francisco General Hospital, Health Access Foundation also has a second Remote Voice and Video Medical Interpretation (RVVMI) project. This effort, based starting at San Joaquin San Joaquin Medical Center, is developing a shared system of interpreter services, to creating a Health Care Interpreter Network. This demonstrates that this solution to the language access problem can be implemented in institutions that previously did not have significant interpretation infrastructure, and can be used to get those providers up and running in an efficient and cost-effective manner. More information about both projects is attached.

What we have learned from both these projects is that it is possible to provide trained medical interpretation services in a cost-effective manner, even in the settings with the greatest demands and barriers.

Video medical interpretation is a far more cost effective means of delivering interpretation services than use of in-person interpreters. While use of an in-person interpreter remains the preferred mode of providing language access, its cost and the practical barriers to having an adequate range of languages available have made it difficult to assure language access using in-person interpreters. Video medical interpretation allows provision of language access in matter of minutes rather than hours. It is a more cost effective use of the interpreter's time: interpreters stay in a single location rather than being carted around a large medical facility or from doctor's office to clinic to hospital.

Video medical interpretation is also more cost effective than telephone interpretation services: the ability of the patient, the physician and the interpreter each to see the other two adds dramatically to the speed and accuracy of communication. Further, many of the phone interpretation services do not specialize in medical interpretation and as we all know, the language of medicine is different and specialized. How often in daily life does one discuss tetanus shots or pap smears?

Video-medical interpretation is another version of tele-medicine. It places the clinician and the patient in the same room with the medical interpreter on the video screen with television-style quality. It makes interpretation services more readily available for a wider array of languages at lower cost. Adoption of this technology concurrent with the introduction of electronic medical records has the potential to allow cost-effective access to medical interpretation. Health Access Foundation has tested this idea in the challenging setting of under-funded county health systems and found that it was possible to go to scale in these challenging settings.

To reiterate Health Access's interest in this project, we have been the incubator for this effort, and are in the process of spinning it off to the hospitals to carry the work forward.

4. Interpretation Services Available at No Cost to Enrollees

Health Access strongly supports the provision of interpretation services at no cost to the enrollee. Interpretation services are minimums for accessing care, for accessing the system that pays for care, and for resolving grievances or disputes with a plan.

While we recognize that co-pays, deductibles and other out of pocket costs are routinely imposed for other services, we feel strongly that interpretation services are a minimum threshold. If an enrollee cannot communicate, their access to care is impaired. Testimony at the hearings demonstrated that the lives of enrollees are literally at risk because of lack of access to interpretation services. Given that enrollees who need interpretation services are more likely to be low or moderate income working people, prohibiting the imposition of out of pocket costs for interpretation services is literally a matter of life and death for some enrollees.

5. Posting in Provider Offices: Strongly Oppose Elimination of 1300.67.8 (f)

Health Access very strongly opposes the deletion of 1300.67.8 (f) in its entirety. This section is not only about language access: it also gives notice to all enrollees of their rights. We recognize that some provisions of this section deal with language access but others do not. Deleting the sections that deal with posting of notice regarding how to contact the plan, file a complaint, obtain assistance from the Department and seek an independent medical review is an error.

We offer alternative language:

> *(f) The contract shall require providers to display in a prominent place in each reception and waiting area a notice informing subscribers and enrollees how to contact their plan, file a complaint with their plan, obtain assistance from the Department, and seek an independent medical review. For the purposes of this regulation, a reception and waiting area shall be defined as a room used for the purpose of subscribers and enrollees waiting to receive services from a provider.*
>
> ~~*(1) The notice shall be displayed in English and in any individually identifiable language that is spoken in the home by ten percent (10%) or more of the households in the U.S. Postal Service ZIP code in which the reception or waiting area is located, according to the US Census Bureau's Census 2000 Summary File 3, Quick Table – P16 for the appropriate ZIP code, which is incorporated by reference.*~~
>
> ~~*(2)*~~ *(1) The notice shall be in a form prescribed, provided and translated by the Department for posting.*

~~(3)~~ (2) The notice and translations can be found at www.dmhc.ca.gov and are available for downloading and printing. In the alternative, hard copies of the notice and translations may be obtained by submitting a written request to the Department of Managed Health Care, Attn: Waiting Room Notices, 980 - 9th Street, Suite 500, Sacramento, CA 95814.

~~(4)~~ (3) Display of a notice provided by the Office of the Patient Advocate containing the information required by this subsection and in the appropriate language(s) will be considered compliance with these regulations.

Upon the effective date of these regulations, plans shall require providers to post said notice. The provision requiring the notice shall be added to all contracts executed subsequent to the effective date of these regulations.

~~(5) A provider who demonstrates to the satisfaction of the Department that the provider's actual patient population is made up of less than five percent (5%) of patients speaking any of the languages for which translations are required under subsection (f)(1) above, may be exempt from displaying a translation in the particular language for which a satisfactory demonstration has been made.~~

1300.67.8 (f) is intended to provide notice to all enrollees of their rights. Eliminating this section is a substantial step back to the dark days when few complaints about HMOs were received by the Department of Corporations because no real consumer knew it existed.

6. Medicare: Strongly oppose current language

Health Access strongly opposes the proposed language in 1300.67.04 (a) (1) that simply states that this regulation shall not apply to plan contracts for provision of services to Medicare enrollees.

We object strongly because this is inconsistent with SB853 and with AB1359 (Chan) of 2005. Specifically, AB1359 was passed in part to allow language access standards for the new Medicare Part D plans that are licensed by the department. While we recognize that federal law is less clear than we would prefer, simply giving up the opportunity to provide Californians with better protections without even trying is just wrong.

We already have numerous examples of Californians who lack language access under the Medicare Part D program: the initial round of problems arises from the auto-assignment of those covered by both Medicare and Medi-Cal (the so-called "Medi-Medis" or dual eligibles). But we anticipate that among the 3.5 million Californians covered by Medicare but not Medi-Cal, we will have additional language access problems.

7. Medi-Cal: Deemed Status: Lacks Clarity

The language with respect to Medi-Cal deemed status either lacks clarity, is inconsistent with existing law, or both.

Specifically, Sec. 1367.04 excludes a plan's Medi-Cal population. However, 1300.67.04 (a) (2) allows a plan to be "deemed in compliance" if it applies the Medi-Cal standards for language assistance programs to the non-Medi-Cal lines of business.

The statute specifically allows the department to rely on audits and other enforcement by the Department of Health Services. But DHS will only oversee and enforce with respect to the Medi-Cal population. So who's checking to see that the non-Medi-Cal population actually gets care in compliance with the Medi-Cal standard? That's the obligation of DMHC rather than DHS.

The language of 1300.67.04 (a) (3) is unclear (or inconsistent with the statute) because it does not state that the plan must demonstrate to DMHC that language access consistent with the Medi-Cal standards is provided to its non-Medi-Cal enrollees.

Please note: we do not object to a plan providing the same level of language access required under Medi-Cal for its non-Medi-Cal enrollees. We just want to make sure that it actually does.

8. Conclusion

The language access regulations are an important step forward in assuring that Californians can get the care they need in the language they speak. In a majority-minority state noted for its diversity, language access is a basic health protection, as basic as an adequate network of providers. Others have provided ample and heart-wrenching testimony about bad health outcomes due to lack of language access. The Department of Managed Health Care and the Office of Patient Advocate did landmark work in creating and improving the element of the HMO report card that addresses language access issues. These regulations that create the basic framework of regulation for language access are landmark as well. It is important that we get it right.

For more information, please contact our advocate, Beth Capell, Capell & Assoc., at (916) 497-0760.

Sincerely,

Anthony Wright
Executive Director

CC: Senator Marta Escutia, Author, SB853